VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05293

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: GREENVILLE
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 12 YRS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Greenville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ada Anderson

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: HARRY C. ANDERSON

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): MARCH, 4, 1872

8. AGE: Years: 68 Months: 2 Days: 15 If less than one day ____ hrs. ____ min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business: NONE

FATHER
12. Name: JOHN T. SAKERS
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: FANNIE NICHOLS
15. Birthplace: MARYLAND

16. Informant: JOHN H. SAKERS
Address: 1009 W. 38th. ST.

17. BURIAL
(Burial, cremation, or removal. Which?)
Date thereof: MAY 22 1940
(month) (day) (year)

Cemetery or crematory: IVY HILL

Location: LAUREL Md

18. Funeral director: C. H. Weer
Address: Sykesville Md.

19. May 20 1940 (Date rec'd by registrar) C. Harry Weer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1940, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1940, to death, 19__, and that I last saw her alive on May 18 1940.

Immediate cause of death: Senility

Due to: Arteriosclerosis

Chronic myocarditis

Due to: Duration: several years. CWGR

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: month,

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. H. Lawson, M. D. or other

Address: Sykesville Md. Date signed: 5/20/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05294

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland -

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years 6 mo 28 days -

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 7 yrs. 6 mo. 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park -

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Franklin G. Anderson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 25 - 1906

8. AGE: Years	Months	Days	If less than one day
34	3	4 -	hrs. min.

9. Birthplace: New Jersey -

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Gustave A Anderson

13. Birthplace: Sweden

MOTHER 14. Maiden name: Josephine A. Riley

15. Birthplace: Pennsylvania

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31, 1940 (month) (day) (year)

Cemetery or crematory: Washington

Location: Washington D.C.

18. Funeral director: Frank A. Newell

Address: Sykesville, Md.

19. May 29 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1940, at 7:05 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1940, to May 29 1940 and that I last saw him alive on May 28 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 7 -
Due to	1940 -
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. - M. D. or other

Address: Sykesville, Md. Date signed May 29 1940.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93rd)

05295

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town near Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) about 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(o) IF VETERAN, NAME WAR no

3. (a) FULL NAME John S. Bixler
3. (b) Social Security Number none

4. Sex male
5. Color or race white
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Laura K. Bixler
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 28 1871

8. AGE: Years 69 Months — Days 22 If less than one day — hrs. — min.

9. Birthplace Littlestown, Pa.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business agriculture
FATHER
12. Name Jacob Bixler
13. Birthplace Maryland
MOTHER
14. Maiden name Amelia Shaffer
15. Birthplace Maryland
16. Informant Mrs. Laura K. Bixler
Address Hampstead, Md. R.D. 2
17. Burial Date thereof 5-29-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester Md
18. Funeral director Jacob Wink's Sons
Address Manchester Md
19. May 20 1940 Mildred S. Hughes (deputy) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20th 1940, at 10 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .
Immediate cause of death chronic myocarditis — DURATION 5 yrs. ?
Due to
Due to Bed fast for 7 years due to hip injury and spinal injury.
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Billingslea (acting Coroner)
M. D. or other
Address Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05296

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: near Ridgeville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D. C. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 608 M. S. E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James H. Bradshaw

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 21, 1922

8. AGE:

Years	Months	Days	If less than one day
17	4	29	hrs. min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: Building
FATHER 12. Name: James H. Bradshaw
13. Birthplace: Va.
MOTHER 14. Maiden name: Mattie Hicks
15. Birthplace: Va
16. Informant: Raymond Bradshaw (Bro)
Address: 608 M. St. S.E. Washington
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26 1940 (month) (day) (year)
Cemetery or crematory: Vicksville Va.
Location: Ivor Va.
18. Funeral director: H. M. Snyder
Address: Mt. Airy
19. May 23 1940 (Date rec'd by registrar) Wm. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1940, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1940, to May 20 1940, and that I last saw him alive on May 19 1940.

Immediate cause of death	DURATION
Due to Pulmonary Tuberculosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy Md Date signed 5/25/40

RECEIVED
JUN 6 1940
BUREAU V. S.

05297

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-b

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 months, 1 day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1308 Harlem Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Walter Brown

3. (b) Social Security Number: none 250-07-9142

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1909

8. AGE:

Years	Months	Days	If less than one day
30	9	4	hrs. min.

9. Birthplace: Spartanburg, S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Will Brown
13. Birthplace: Fairfield, S. C.

MOTHER
14. Maiden name: Mary Fester
15. Birthplace: Fairfield, S. C.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 5/6/1940 (month) (day) (year)

Cemetery or crematory:

Location: Spartensburg S.C.

18. Funeral director: Mrs Katie H. Williams

Address: 322 N. Schroeder St.

19. 5/5/40 19 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1940 19 5:30 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1940 19 to May 5, 1940 and that I last saw him alive on May 5, 1940 19

Immediate cause of death: Pulmonary Tuberculosis

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

DURATION: Nov. 1939

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed: 5/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 20 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05298

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 mos., 24 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Maria Virginia Carter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 25, 1916

8. AGE:

Years	Months	Days	If less than one day
23	5	28	hrs. min.

9. Birthplace: Ellicott City, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: James Carter
13. Birthplace: Ellicott City, Maryland

MOTHER
14. Maiden name: Maria Fuller
15. Birthplace: Ellicott City, Maryland

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25 1940 (month) (day) (year)
Cemetery or crematory: Fuller Family Cem.
Location: Pine orchard Howard Co.
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. 5/23/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1940 19 , at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29, 1940 19 , to May 23 19 40 , and that I last saw h er alive on May 23, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct, 1939
Due to --
Due to --
Other conditions --
(Include pregnancy within 3 months of death)
Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) -- (County) -- (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 5/23/40

RECEIVED
JUN 4 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (132)

CERTIFICATE OF DEATH

05299

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or insl. (yrs., or mos., or days): 1 month
Stay in this community (yrs., or mos., or days): 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 2118 E. Fayette St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Chesser

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mrs. John Chesser
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 6, 1890

8. AGE: Years	Months	Days	If less than one day
49	11	6	____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Carpenter
11. Indusfry or business: U.S. Coast Guard
FATHER 12. Name: Martin Chesser
13. Birthplace: Virginia
MOTHER 14. Maiden name: Catherine Ewell
15. Birthplace: Virginia
16. Informant: Mrs. John Chesser
Address: 2118 E. Fayette St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1940 (month) (day) (year)
Cemetery or crematory: Loudon Park
Locafion: Baptimore, Md.
18. Funeral director: John Ulrich
Address: 2008 Orleans St.
19. May 12, 1940 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1940, at 6 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1940, to May 12, 1940, and that I last saw him alive on May 11, 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1½ yrs
Due to	
Due to	
Other conditions: Generalized Arterio-sclerosis (Include pregnancy within 3 months of death)	Prior to 4/2/40

Major findings:
Of operations:
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, indusfry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alan Jacobsen M. D. or other
Address: Spring Lake State Hosp Date signed 5/13/40

RECEIVED
MAY 16 1940
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (92d)

05300

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital,
Stay in hospital or inst. (yrs., or mos., or days) 31 yrs., 9 mos., 18 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR #

3. (a) FULL NAME Herbert Hall Conn.

3. (b) Social Security Number #

4. Sex: Male.
5. Color or race: White.
6. (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife —
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) 1867 (exact date unknown)

8. AGE: Years 72. Months Unk. Days Unk. If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Clerk.
11. Industry or business Unknown
FATHER 12. Name William Conn.
13. Birthplace Maryland.
MOTHER 14. Maiden name Elizabeth R. Moran.
15. Birthplace Maryland.
16. Informant Springfield Hospital Record,
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9th 1940 (month) (day) (year)
Cemetery or crematory Greenmount Cemt
Location Balto Md
18. Funeral director Bertram Fox
Address 2224 N Charles St.
19. May 7 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1940, at 8.40 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936, to May 6, 1940, and that I last saw him alive on May 6, 1940.

Immediate cause of death ~~Acute~~ Endocarditis — ~~one week~~. Chronic (Valvular Heart Disease)
Due to Cardiac Hypertrophy Dilatation — over 1 year
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy As above

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE Harry F. Baer, M.D. M. D. or other
Address Sykesville, Md. Date signed 5/6/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 17 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

05301

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Spring Field State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 months

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 516 N. Charles St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mary Coyle

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years: 78 | Months: — | Days: — | If less than one day: — hrs. — min.

9. Birthplace: Baltimore, (Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business: Public schools

FATHER 12. Name: John Coyle

FATHER 13. Birthplace: Baltimore

MOTHER 14. Maiden name: Maggie —

MOTHER 15. Birthplace: Unknown

16. Informant: Mrs. Daddysman

Address: 516 N. Charles St. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1940 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md.

18. Funeral director: Walter B. Bradley

Address: 1922 N. North Ave.

19. May 17 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1940, at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16th 1939, to May 17 1940, and that I last saw h[illegible] alive on May 17 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: Arterio Sclerosis	?
Due to: Chronic Myocarditis with aortic rotic pseudon changes. Cyst Kidney	?
Other conditions: Extreme (extensive) cardiac involvement.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: W. W. Martin M. D. or other

Address: Sykesville Date signed: May 17 40

RECEIVED
MAY 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

05302

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium (Colored Branch)
Stay in hospital or inst. (yrs., or mos., or days): 4 mos., 1 day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 22 S. Court Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: EDWARD FRANCIS DORSEY

3. (b) Social Security Number: 214-10-2305

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6 (b) Name of husband or wife: --
6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1906

8. AGE: Years	Months	Days	If less than one day
34	3	6	-- hrs. -- min.

9. Birthplace: Frederick, Md.
(Town, county, and state)

10. Usual occupation: Bell Hop

11. Industry or business: Hotel

FATHER
12. Name: John Dorsey
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Maggie Murdock
15. Birthplace: Buckeystown, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/1940 (month) (day) (year)
Cemetery or crematory: Parkview
Location: near Frederick, Md
18. Funeral director: M. E. Etchinson & Son
Address: Frederick, Md

19. May 26 1940 (Date rec'd by registrar) Albert R. Swankhamer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1940, at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25, 1940 to May 26 1940, and that I last saw him alive on May 26 1940.

Immediate cause of death	DURATION
Pulmonary tuberculosis	Began April 1939
Due to --	
Due to --	
Other conditions --	
--	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/26/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05303

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 1 month, 21 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salsibury Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Ocean City Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ella Farlow

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1923

8. AGE: Years	Months	Days	If less than one day
17	0	5	hrs. min.

9. Birthplace Salisbury, Maryland (Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

FATHER 12. Name Charlie Farlow

13. Birthplace Unknown

MOTHER 14. Maiden name Hesther Custice

15. Birthplace unknown

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1940 (month) (day) (year)

Cemetery or crematory Glasshill

Location Parsonsburg

18. Funeral director James F. Stewart

Address Baltimore md

19. 5/29/40 19 (Date rec'd by registrar) Albert R. Swankhaus Registrar Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1940 19 , at 11:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1940 19 , to May 29, 1940 , and that I last saw her alive on May 29, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to --	
Due to --	
--	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D. M. D. or other

Address Henryton, Maryland Superintendent Date signed 5/29/40

RECEIVED
JUN 4 1940
BUREAU V. S.

05304

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs 10 mo 5 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 25 yrs 10 mo 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frances Francisco

3. (b) Social Security Number

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced Unknown

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 85 Months Days If less than one day hrs. min.

Apparent Age

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Hospital Records

Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1940 (month) (day) (year)

Cemetery or crematory Springfield Hospital Cem.

Location Sykesville Md.

18. Funeral director C. Harry Weir

Address Sykesville Md.

19. May 15 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1940, at 5:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1940, to May 12 1940 and that I last saw her alive on May 11 1940

Immediate cause of death Myocardial infarction with rupture of left ventricle Arteriosclerosis

DURATION 1925

Due to coronary occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other

Address Sykesville Md. Date signed 5-12-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05305

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 1 yr., 2 mos., 15 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Mechanicsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Thomas Matthew Goldring

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1922

8. AGE: Years 18 | Months 0 | Days 29 | If less than one day hrs. min.

9. Birthplace Oarville, Maryland (Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

FATHER
12. Name Moses Goldring
13. Birthplace Oarville, Maryland

MOTHER
14. Maiden name Estelle Key
15. Birthplace Oarville, Maryland

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/20/1940 (month) (day) (year)
Cemetery or crematory St Lukes
Location Sykesville, Md
18. Funeral director T. E. Swann
Address Sykesville, Md

19. 5/18/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1940 19 , at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1939 19 , to May 18, 1940 , and that I last saw h im alive on May 18, 1940 19

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) -- (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
Superintendent M. D. or other
Address Henryton, Maryland Date signed 5/18/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13-L

05306

Reg. Dist. No. 7-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years 2 mo. 15 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 years, 2 mo. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1601 Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Anna Grasser

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Unknown -

8. AGE:

Years	Months	Days	If less than one day
32	-		hrs. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: George Grasser
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Pfister
15. Birthplace: Germany

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20, 40 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18. Funeral director: John C. Sullivan Inc.
Address: 4336 Olive St.

19. May 16 1940 (Date rec'd by registrar) Anna Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Tuberculous Pneumonia of Right Lung -	April 4-40
Due to	
Due to	
Other conditions	More than 20 years.

Epilepsy
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results: As above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other
Address: Sykesville, Md. Date signed: May 16-1940

RECEIVED
MAY 20 1940
BUREAU V. S.

05307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13E)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 4 mos., 8 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7 N. Eden St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Green

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife unknown

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1916

8. AGE: Years 24 | Months 2 | Days 3 | If less than one day hrs. min.

9. Birthplace Aulander, N. C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER: 12. Name Edward Taylor

13. Birthplace North Carolina

MOTHER: 14. Maiden name Gurnie Perry

15. Birthplace North Carolina

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1940 (month) (day) (year)

Cemetery or crematory

Location Balto. Md.

18. Funeral director Mrs Frances A. Hemsley

Address 578 W Biddle St.

19. 5/14/40 19 (Date rec'd by registrar) Albert R. Swankhouse Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1940 19 , at 12:55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1940 19 , to May 14, 1940 19 , and that I last saw her alive on May 14, 1940 19

Immediate cause of death Pulmonary Tuberculosis

Due to --

Due to --

Other conditions

(Include pregnancy within 3 months of death)

Major findings: --

Of operations

Of autopsy Autopsy performed 5/15/40

DURATION Aug. 1939

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M.D. or other

Address Henryton, Maryland Superintendent Date signed 5/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82)

Reg. Dist. No. 78

05308

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural Westminster (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 2 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Carroll

(c) City or town Rural Westminster (If outside city or town limits, write RURAL and give town)

(d) Street No. near Taylorsville (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Margaret Catherine Haines

3 (b) If veteran, name war

3 (c) Social Security No. 216-05-2182

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 10-1918

8. AGE: Years 22 Months 4 Days 10 If less than one day ____ hr. ____ min.

9. Birthplace Pleasant Valley Md. (Town, county, and state)

10. Usual occupation Sewing Factory

11. Industry or business Machine Operator

FATHER

12. Name Walter T. Haines

13. Birthplace Uniontown Md.

MOTHER

14. Maiden Name Mary Wantz

15. Birthplace Pleasant Valley Md.

16 (a) Informant Walter T. Haines

(b) Address Westminster Md. R.D 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22-1940 (month) (day) (year)

(c) Cemetery or crematory Pleasant Valley Cem.

Location near Fuzzalburg Md.

18 (a) Funeral director W. W. Hartzler & Sons

(b) Address New Windsor Md.

19 (a) May 21, 1940 (Date rec'd by registrar) (b) E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. Date of death May 20 1940, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1939, to May 20 1940, and that I last saw him alive on May 19 1940.

Immediate cause of death Respiratory Paralysis

Due to Progressive Muscular Dystrophy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration: 2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jas. T. Marsh M.D. M. D. or other

Address New Windsor Md Date signed 5/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05309

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 4 mos., 12 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Anne
City or town Grasonville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Emma Darfield Hammond
3. (b) Social Security Number: 215-18-4879

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 28, 1914
8. AGE: Years 25 | Months 9 | Days 13 | If less than one day hrs. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: Henry Riveles
13. Birthplace: unknown
MOTHER 14. Maiden name: Ella Hammond
15. Birthplace: unknown
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mag 5/5/40 (month) (day) (year)
Cemetery or crematory: Mt Calvg.
Location
18. Funeral director: Alexander Halstead
Address: 9 / 8 Bond Hill ave.
19. 5/11/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1940 19 , at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29, 1939 to May 11, 1940, and that I last saw her alive on May 11, 1940 19
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1939
Due to --
Due to --
Other conditions --
(Include pregnancy within 3 months of death)
Major findings:
Of operations --
Of autopsy --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed 5/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 15 1940
BUREAU V. S.

05310

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Keymar
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hannah Hann

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Hayden Hann
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 8, 1883

8. AGE: Years	Months	Days	If less than one day
56	10	12	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Oliver Plain
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maggie Shoemaker
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24-40 (month) (day) (year)
Cemetery or crematory: Mt Zion Methodist
Location: Frederick Co
18. Funeral director: C. O. Fuss and Sauer
Address: Lawyers Town

19. May 21 1940 (Date rec'd by registrar) C. Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20th 1940 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9th 1940, to May 20 1940 and that I last saw her alive on May 20 1940

Immediate cause of death	DURATION
Cerebral Infarction due to	Known
Cerebral Arteriosclerosis	May 21-1940
Due to: Cardiac Infarct - due to	May 21-1940
Due to: Coronary artery occlusion	
Other conditions: Hydronephrosis due to	May 21-1940
Pelvic Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Berger M.D. M. D. or other
Address: Sykesville, Md. Date signed: 5/21/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

05311

CERTIFICATE OF DEATH

Reg. Diat. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harvey A. Harry

3. (b) Social Security Number 218-03-1702

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6 (b) Name of husband or wife Rosa L. Harry
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1877

8. AGE: Years 62 | Months 11 | Days 28 | If less than one day ____hrs. ____min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Cement Co. employee

11. Industry or business until 6/10/1939

FATHER 12. Name unknown
13. Birthplace unknown

MOTHER 14. Maiden name Emma Harry
15. Birthplace Md.

16. Informant Margaret H. Harry
Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4, 1940 (month) (day) (year)

Cemetery or crematory Cemetery Hauger's
Location near Keymar, Md

18. Funeral director C. O. Fuss & Son
Address Taneytown Md.

19. May 3 1940 (Date rec'd by registrar) H. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2-1940, at 39 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/18-40, 19__, to 5-2-1940, and that I last saw h alive on 5-1-1940.

Immediate cause of death Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. H. Hagg M. D. or other
Address Union Bridge Date signed 5/3/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

05312

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 8 months, 6 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 628 N. Gilmor St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eleanor Beatrice Henderson

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1914

8. AGE: Years	Months	Days	If less than one day
26	0	19	hrs. min.

9. Birthplace Catonsville, Maryland
(Town, county, and state)

10. Usual occupation Maid

11. Industry or business

FATHER 12. Name Joseph Henderson
13. Birthplace Catonsville, Maryland

MOTHER 14. Maiden name Rosie Burton
15. Birthplace Baltimore, Maryland

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 1940 (month) (day) (year)
Cemetery or crematory Western Star
Location Catonsville, Md.

18. Funeral director S. W. Chase & Sons
Address 638 N. Gilmor St.

19. 5/16/40 19 (Date rec'd by registrar) Albert R. Swanhaus Registrar
Deputy Local

MEDICAL CERTIFICATION 10:00 A.M.

20. DATE OF DEATH May 16, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10, 1939 to May 16, 1940
and that I last saw her alive on May 16, 1940

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1939
Due to --	
Due to --	
Other conditions --	
(Include pregnancy within 3 months of death)	
Major findings:	
Of operations --	
Of autopsy --	

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- -- --
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D.
Superintendent M. D. or other
Address Henryton, Maryland Date signed 5/16/40

RECEIVED
MAY 17 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (90-E)

05313

CERTIFICATE OF DEATH

Reg. Dist. No. 7 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Taneytown R.D.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Taneytown, R.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR (-)

3. (a) FULL NAME Mrs Laura E. Hilterbrick
3. (b) Social Security Number none

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced widow
6 (b) Name of husband or wife Luther E. Hilterbrick
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 26, 1875
8. AGE: Years 65 Months 2 Days 1 If less than one day hrs. min.
9. Birthplace Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Samuel Slagenhaupt
13. Birthplace Md.
MOTHER 14. Maiden name Mary J. Creamer
15. Birthplace Md
16. Informant Mrs. Blanche Kiser
Address Taneytown, R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29-40 (month) (day) (year)
Cemetery or crematory United Brethren
Location Harney, Md
18. Funeral director C. O. Fuss & Son
Address Taneytown Md.
19. May 29 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24th 1940, at 3.15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1940, to May 25 1940, and that I last saw h alive on May 25 1940.

	DURATION
Immediate cause of death Pericarditis	19 days.
Due to Acute Purulent Otitis Media	13 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Francis D. Elliot, M.D.
M. D. or other
Address Taneytown Md. Date signed 5/28/40

RECEIVED
JUN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05314

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 1 month, 22 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lester Holloway

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Elizabeth Holloway
Snow Hill, Md. 6(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.): April 4, 1907

8. AGE: Years	Months	Days	If less than one day
33	1	5	hrs. min.

9. Birthplace: Snow Hill, Worcester Co., Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Levin Holloway
13. Birthplace: Snow Hill, Maryland

MOTHER
14. Maiden name: Ella Corner
15. Birthplace: unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1940 (month) (day) (year)
Cemetery or crematory: Snow Hill Cem.
Location: Snow Hill Md.
18. Funeral director: C. Harry Weir
Address: Sykesville, Md.

19. 5/9/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION 2:20 P.M.

20. DATE OF DEATH May 9, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17, 1940 19 , to May 9, 1940 19 , and that I last saw h im alive on May 9, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy ---

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
Superintendent M. D. or other
Address Henryton, Maryland Date signed 5/9/40

RECEIVED
MAY 16 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

05315

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4300 Cinnamon Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Albert W. Ireland

3. (b) Social Security Number 212-01-6862

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeth Everly

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): August 8, 1882

8. AGE: Years 56 | Months 9 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: John Ireland
13. Birthplace: Connecticut

MOTHER
14. Maiden name: Clementine Michael
15. Birthplace: Baltimore, Md

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16/40 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Balto Md

18. Funeral director: William Cook

Address: 1217 St Paul St

19. May 14 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1940, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1940, to May 13 1940 and that I last saw him alive on May 13 1940

Immediate cause of death	DURATION
Chronic Intestinal Bleeding due to Peptic Ulcer	at Autopsy
Due to Chronic Myocarditis and Myocardial Degeneration	Known May 2-1940
Other conditions Acute Prostatic Abscess	at Autopsy

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer MD - M. D. or other

Address Sykesville, Md. Date signed May 13-1940

Authorization to change date of birth see letter filed under Beyer in permanent file. 5-27-40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(95-2)

05316

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - n. Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Westminster, Md

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Thomas Franklin Keefer

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name ~~of husband~~ or wife: Lydia Keefer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1858

8. AGE: Years	Months	Days	If less than one day
81	5	19	..... hrs. ..... min.

9. Birthplace: Taneytown, Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER — 12. Name: William Keefer

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Sarah Koontz

15. Birthplace: Maryland.

16. Informant: Mr. John W. Keefer

Address: R.D. Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1940 (month) (day) (year)

Cemetery or crematory: Taneytown Reformed

Location: Taneytown, Carroll Co. Md

18. Funeral director: C.M. Walter

Address: Winfield Md.

19. May 4 - 1940 (Date rec'd by registrar) C.M. Fairer Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1940, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 16 1940, to May 3 1940

and that I last saw him alive on May 2 1940

Immediate cause of death	DURATION
Cardiac Dilatation	—
Due to: Arteriosclerosis	yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Jas. T. Shaum M.D. M. D. or other

Address: Westminster Md. Date signed May 3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 13 1
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-2

05317

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or insl. (yrs., or mos., or days) 1 yr 2 7 days

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1416 Gough St. Baltimore

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Emelie Klessler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6 (b) Name of husband or wife George Klessler

6(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) unknown.

8. AGE:

Years	Months	Days	If less than one day
89			____ hrs. ____ min.

9. Birthplace Hessen Germany

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Martin Klessler

13. Birthplace Germany

MOTHER

14. Maiden name unknown

15. Birthplace Germany

16. Informant Mrs. Cornelia Preller

Address 2008 Kennedy Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1940 (month) (day) (year)

Cemetery or crematory Greenfield Hosp. Cemetery

Location Sykesville Md.

18. Funeral director C. Harry Teer

Address Sykesville Md.

19. 5-21-1940 (Date rec'd by registrar) C. Harry Teer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th 1940, at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1939, to May 16 1940, and that I last saw h er alive on May 16th 1940.

Immediate cause of death	DURATION
a. Arteriosclerotic heart disease	
Due to b. Generalized Arteriosclerosis	1 yr
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D. M. D. or other

Address Springfield State Hospital Date signed May 21 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83a)

05318

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:
County Carroll
City or town Detour
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Detour Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME John Eli Lawrence
3. (b) Social Security Number No.

4. Sex M
5. Color or race W.
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Hattie Lawrence
6(c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) June 12 - 1864

8. AGE: Years 75 Months 10 Days 22 If less than one day ___ hrs. ___ min.

9. Birthplace Taneytown Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business General
FATHER 12. Name Jerome Lawrence
13. Birthplace Taneytown Md
MOTHER 14. Maiden name Racheal Sowers
15. Birthplace Unknown
16. Informant Mrs. Hattie Lawrence
Address Detour Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6 1940 (month) (day) (year)
Cemetery or crematory Cemetery
Location Haughs
18. Funeral director C. O. Fuss & Son
Address Taneytown
19. May 4 1940 (Date rec'd by registrar) Mrs. Rhea S. Diller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1940, at 4 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —,
and that I last saw h — alive on — 19 —.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis
Due to
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy None

DURATION
7
7

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide No Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE J. T. March - Deputy Medical Examiner M. D. or other
Address New Windsor Md Date signed May 4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05319

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., *or* mos., *or* days) 2 months, 4 days
Stay in this community (yrs., *or* mos., *or* days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 111 N. Mount St.
(If rural give LOCATION)
2(*c*) IF VETERAN, NAME WAR

3. (*a*) FULL NAME Julia Pauline Leach

3. (*b*) Social Security Number

4. Sex	5. Color or race	6.(*a*) Single, married, widowed, or divorced
Female	Colored	Single

6 (*b*) Name of husband or wife
6(*c*) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1924

8. AGE: Years	Months	Days	If less than one day
16	1	13	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Scholar
11. Industry or business

FATHER
12. Name Claude Leach
13. Birthplace Raliegh, N. C.

MOTHER
14. Maiden name Maggie Hallen
15. Birthplace Wallsville, Maryland

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-19-40 (month) (day) (year)
Cemetery or crematory Arbutus
Location Balto. County
18. Funeral director Saml. M. Chase & Son
Address 638 N. Gilmor St.
19. 5/15/40 19 (Date rec'd by registrar) Albert R. Swankhouse Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1940 19 , at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 1940, to May 15, 1940, and that I last saw her alive on May 15, 1940 19

Immediate cause of death	Pulmonary Tuberculosis	Dec. 1939
Due to	--	
Due to	--	
Other conditions	--	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D.
Superintendent M. D. or other
Address Henryton, Maryland Date signed 5/15/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05320

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2months, 3 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Ridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Amanda Lee

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 20, 1925

8. AGE: Years	Months	Days	If less than one day
14	7	26	hrs. min.

9. Birthplace: Ridge, St. Mary's County, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER — 12. Name: Roy Lee
13. Birthplace: Ridge, St. Mary's Co., Md.

MOTHER — 14. Maiden name: Pearl Smith
15. Birthplace: Ridge, St. Mary's Co., Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/40 (month) (day) (year)

Cemetery or crematory: St Peters

Location: Ridge Md.

18. Funeral director: E. T. Robinson

Address: Cameron Md.

19. 5/16/40 (Date rec'd by registrar) 19 — Albert R. Swankhaus, Registrar, Deputy Local

MEDICAL CERTIFICATION 9:50 P.M.

20. DATE OF DEATH: May 16, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1940 19 , to May 16, 1940 19 , and that I last saw her alive on May 16, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan, 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 5/16/40

RECEIVED
JUN 4 1940
BUREAU V. S.

05321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Carroll

City or town Cedarhurst (Rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 9 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Cedarhurst (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joshua. A. Martin.

3. (b) Social Security Number 215-10-2626

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maude Hesson Martin

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 16, 1874

8. AGE: Years 65 Months 11 Days 3 If less than one day ___ hrs. ___ min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm owner.

FATHER
12. Name William Martin
13. Birthplace Carroll Co, Maryland

MOTHER
14. Maiden name Elizabeth Stansbury.
15. Birthplace Carroll Co, Maryland

16. Informant Blanchard D. Martin

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22 - 1940 (month) (day) (year)

Cemetery or crematory Pipe Creek Cem.

Location New Windsor - Uniontown Road.

18. Funeral director D. D. Hartzler & Sons

Address Union Bridge, Md.

19. May 21 1940 (Date rec'd by registrar) C. R. Fogle Dep Loc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1940, at 18 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Coronary Thrombosis

DURATION Few minutes

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Billingsley (Acting Coroner) M. D. or other

Address Westminster, Md. Date signed 5/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05322

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Oakland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 4 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Oakland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Charles H. Murray

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Jennie Murray
6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1883

8. AGE: Years	Months	Days	If less than one day
56	8	8	hrs. min.

9. Birthplace: Balto. Co.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Wm. A. H. Murray
13. Birthplace: Balto. City
MOTHER 14. Maiden name: Barbara A. Nash
15. Birthplace: Balto. Co.
16. Informant: Mrs. Mary A. Yox
Address: Reisterstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15, 1940 (month) (day) (year)
Cemetery or crematory: Deer Park
Location: Balto. Co.
18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.
19. May 14 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 13 1937, to May 13 1940, and that I last saw him alive on May 12 1940.

Immediate cause of death	DURATION
Myocardial Insufficiency	18 mo.
Due to Undetermined.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: None.
Of autopsy: None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): None.
Means of injury Injured at work?

23. SIGNATURE: D. D. Eagles, M. D.
M. D. or other
Address: Reisterstown, Md. Date signed: 5-13-'40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05323

Reg. Dist. No. 14

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md -

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 1 mo. 1 day

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 yrs. 1 mo. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Carroll County:

City or town: Taneytown -

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Evelyn Ramsburg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 1, 1915

8. AGE:

Years	Months	Days	If less than one day
25	1	30	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: George Ramsburg

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary —

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1940 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cemetery

Location: Sykesville Md.

18. Funeral director: C. H. Wees

Address: Sykesville Md.

19. May 31 1940 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1940, at 7:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1940, to May 31 1940 and that I last saw h... alive on May 31 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to: Tuberculous Pneumonia	May 25 1940
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Berger M.D. — M. D. or other

Address: Sykesville, Md. Date signed: June 1-1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

05324

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taylorsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 1 yr into 19 yrs

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Raspburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 6 Dell Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Minnie Schlatzer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6 (b) Name of husband or wife: Theodore Schlatzer

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept 18th 1860

8. AGE: Years: 79 | Months: 2 | Days: 19 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Monkton, Maryland (town, county, and state)

10. Usual occupation: Housewife ~~not active~~

11. Industry or business:

FATHER — 12. Name: Michael Rigel

13. Birthplace: Germany

MOTHER — 14. Maiden name: Rose Loefler

15. Birthplace: Germany

16. Informant: Theodore Schlatzer

Address: Raspburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10, 1940 (month) (day) (year)

Cemetery or crematory: Mt Carmel Cem.

Location: Balto. City Md.

18. Funeral director: A. Sander & Son Inc.

Address: North Ave & Broadway

19. May 8 1940 (Date rec'd by registrar) C. Harry Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7th 1940, at 11.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 18 1939, to May 7 1940, and that I last saw her alive on May 7th 1940.

Immediate cause of death	DURATION
Intestinal obstruction due to post-operative intra-abdominal adhesions	1 day
Due to Generalized arteriosclerosis	1 yr. (Known)
Due to Myocardial degeneration	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: As above

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of: ——

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ——

Means of injury: —— Injured at work?

23. SIGNATURE: Joseph H. Marshall, M. D. M. D. or other

Address: Springfield State Hospital Date signed: 5-8-40

RECEIVED
JUN 4 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

05325

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs 3 mo 1 day

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 24 yrs 3 mo. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3308 Chestnut Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eliza E. Shipley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE:

Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Mycagah Shipley
13. Birthplace Virginia

MOTHER
14. Maiden name Margaret Perry
15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1940 (month) (day) (year)

Cemetery or crematory St Marys Cem.

Location Baltimore Md.

18. Funeral director Geo L. Beyer Jr.

Address 1512 Holling St.

19. May 17 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1940, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1925, to May 17 1940 and that I last saw her alive on May 17 1940

Immediate cause of death	DURATION
Chronic Myocarditis and	1933
Due to Myocardial Degeneration	
Due to Arteriosclerosis & Hypertension	1933
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M Virginia Beyer M.D. (M. D. or other)

Address Sykesville, Md Date signed May 17-1940

Authorization to change item 21 see letter filed under Beyer in permanent file. 5/27/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

05326

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 23 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Unknown 177 Penn. Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Nellie M. Shugh

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Unknown Wm. Shugh
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown Aug 20, 1870

8. AGE: Years	Months	Days	If less than one day
70			____ hrs. ____ min.

9. Birthplace Westminster, Maryland
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name William Wilson
13. Birthplace Maryland

MOTHER
14. Maiden name Susan Myerly
15. Birthplace Carroll County, Maryland

16. Informant Hospital Records
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 11 40 (month) (day) (year)
Cemetery or crematory Westminster
Location Westminster, Md.
18. Funeral director J. E. Myers Jr.
Address Westminster, Md.

19. 5/9/40 (Date rec'd by registrar) 19 C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1940, to May 9 1940, and that I last saw her alive on May 8 1940.

Immediate cause of death	DURATION
Arteriosclerosis	Unknown
Left Ventricle myocardial infarction	June 1940
Due to Coronary occlusion	2nd mo
Cerebral infarction rt occipital	
Due to cerebral arteriosclerosis	1st mo

Other conditions Bronchopneumonia — May 7 - 1940

(Include pregnancy within 3 months of death)

Major findings:
Ot operations
Ot autopsy As above

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. Virginia Berger M.D.
M. D. or other
Address Sykesville, Md. Date signed 5-9-40

RECEIVED
JUN 4 1940
BUREAU V. S.

05327

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Hampstead (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harvey C. Snyder

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced widower

6 (b) Name of ~~husband~~ or wife Anna M Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14-1867

8. AGE: Years 72 Months 5 Days 22 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

FATHER 12. Name Elisha Snyder

13. Birthplace Maryland

MOTHER 14. Maiden name Diana Lafferty

15. Birthplace Unknown

16. Informant Mrs Adam Snyder

Address Hampstead Md

17. Burial (Burial, cremation, or removal, Which?) Data thereof May 9-1940 (month) (day) (year)

Cemetery or crematory Greenmount

Location Greenmount Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. May 7 1940 (Date rec'd by registrar) John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1940, at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938, to May 6 1940, and that I last saw him alive on May 6 1940.

Immediate cause of death Cerebral Thrombosis Hemiplegia — DURATION 1 mo

Due to

Due to Arteriosclerosis — ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W R S Denner M. D. or other

Address Manchester Md Date signed 5/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 8 1940
BUREAU V. S.

05328

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-5)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster (Outside)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 115 Liberty

Stay in hospital or inst. (yrs., or mos., or days): No.

Stay in this community (yrs., or mos., or days): 22 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 115 Liberty Street.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lucinda Catherine Snyder

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: white

6. (a) ~~Single, married, widowed, or divorced~~: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): January 1, 1847

8. AGE: Years: 93 Months: 4 Days: 6 If less than one day ____ hrs. ____ min.

9. Birthplace: Gettysburg, Adams Co. Penna.
(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER
12. Name: Nicholas Snyder.
13. Birthplace: Penna.

MOTHER
14. Maiden name: Catherine Fisher
15. Birthplace: Unknown

16. Informant: Edgar Weigle
Address: Mt. Airy, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5/7/40 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Gettysburg Penna.

18. Funeral director: H. B. Bender & Son Per R.O.A.

Address: Gettysburg Penna.

19. 5/7 1940 [signature] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1940, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1936, to May 7 1940, and that I last saw her alive on May 6 1940.

Immediate cause of death: Cardiac asthma (Acute Myocarditis (Chr) Nephritis (Chr. Acute dilatation of heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: None

DURATION: 10 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. C. Jennett Mt. M. D. or other

Address: Westminster Md. Date signed: 5-7-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1940
BUREAU V. S.

05329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4800 Laurel Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes Stewart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William B. Stewart

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 24-1890

8. AGE:

Years	Months	Days	If less than one day
50	1	24	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William J. Cordle
13. Birthplace Richmond, Va.

MOTHER
14. Maiden name Unknown
15. Birthplace Bristol Tenn.

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof May 20-1940
(month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Md.

18. Funeral director Stewart & Mowen Co

Address 108 W. North Ave. Balto Md.

19. May 18 1940 C. Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 9:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1940, to May 18 1940 and that I last saw her alive on May 18 1940

Immediate cause of death Chronic Alcoholic

Due to Acute Alcoholism

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION: Since 1933 - May 11 - 1940 -

Major findings of operations

Date of op.

Autopsy results Not done -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

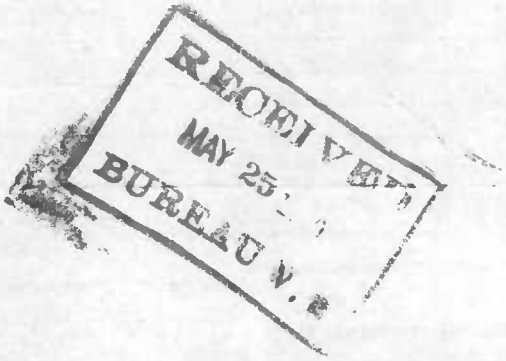
23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed May 18-1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 25
BUREAU V.E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-13)

CERTIFICATE OF DEATH

05339

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: CARROLL
City or town: HAMPSTEAD, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 72 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: HAMPSTEAD, MARYLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: SARAH ELIZABETH ANN SWITZER

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	MARRIED

6 (b) Name of husband or wife: John Franklin Switzer
6(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 25, 1868

8. AGE: Years	Months	Days	If less than one day
72	6	0	— hrs. — min.

9. Birthplace: MANCHESTER, Maryland (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: OWN HOME.

FATHER
12. Name: Michael S. Brilhart.
13. Birthplace: Pennsylvania.

MOTHER
14. Maiden name: Mandilla C. Hoover.
15. Birthplace: Maryland.

16. Informant: J. Franklin Switzer.
Address: HAMPSTEAD, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27-1940 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Hampstead Md
18. Funeral director: Edgar Grafton
Address: Hampstead, Md

19. May 25 1940 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1940, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1940, to May 25 1940, and that I last saw her alive on May 25 1940.

Immediate cause of death	DURATION
CARCINOMA of Stomach	?
Due to —	
Due to —	
Other conditions: Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Joseph E. Bush M.D.
M. D. or other
Address: Hampstead Md Date signed: 5-25-40

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05331

Reg. Dist. No. 7-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jadock Talbert

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of ~~husband~~ or wife Sarah R. Talbert
6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Feb 1 - 1863

8. AGE:

Years	Months	Days	If less than one day
77	3	10	hrs. min.

9. Birthplace Maryland (Town, county and state)
10. Usual occupation Retired farmer
11. Industry or business
FATHER 12. Name William H. Talbert
13. Birthplace Md
MOTHER 14. Maiden name Matilda C Darby
15. Birthplace Md.
16. Informant Mr Thomas Talbert
Address Westminster Md R.D #5
17. Burial Date thereof May 14/40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hampstead
Location Hampstead Md
18. Funeral director Edw Clifton
Address Hampstead Md
19. May 14 1940 Margaret R. Douglas
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1940, to May 10 1940, and that I last saw him alive on May 7 1940.

Immediate cause of death — DURATION
Carcinoma of stomach — ?
Due to
Cue to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. I. Marsh M. D.
M. D. or other
Address New Windsor Md Date signed May 11/40

JUN 5 1940

05332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster Rural near
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 53

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster R.D. # 7 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs A. Florence Thomas

3. (b) Social Security Number None

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband ~~or wife~~ J. Walter Thomas
6(c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.) June 7. 1886

8. AGE: Years 53 Months 10 Days 26 If less than one day ____ hrs. ____ min.

9. Birthplace East Berlin Md. Pennsylvania
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Ezra C. Brown
13. Birthplace Md.
MOTHER 14. Maiden name Elizabeth Gipe
15. Birthplace Pennsylvania
16. Informant J. Walter Thomas
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1940 (month) (day) (year)
Cemetery or crematory Meadowbranch Cemetery
Location Nr. Westminster, Md.
18. Funeral director H Bankard Leon
Address Westminster, Md
19. 5/4 1940 L K Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1940, at 6:45 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1939, to May 3 1940, and that I last saw her alive on May 3 1940.
Immediate cause of death Carcinoma cervix c metastases
DURATION 1 yr.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster Md. Date signed May 4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05333

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 24 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Pocomoke City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Edward Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 18, 1923

8. AGE: Years	Months	Days	If less than one day
17	3	7	hrs. min.

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation: Farm laborer
11. Industry or business

FATHER
12. Name: Elliott King
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-28-40 (month) (day) (year)
Cemetery or crematory: Christ M.E. Cemetery
Location: Pocomoke City Md.
18. Funeral director: John A. Bradshaw
Address: Pocomoke City, Md

19. 5/25/40 (Date rec'd by registrar) 19 Albert R. Swankhaven Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1940 19 , at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1940 19 to May 25, 1940 19 , and that I last saw him alive on May 25, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 5/25/40

RECEIVED
JUN 4 1940
BUREAU V. S.

05334

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs. 8 mo 14 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 22 yrs. 8 mo 14 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 N. Curley St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lena Walter

3. (b) Social Security Number

4. Sex F.

5. Color or race W

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Randolph Walter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1865

8. AGE: Years 75 | Months 3 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Henry Gasser
13. Birthplace Germany

MOTHER
14. Maiden name (Unkn.) Brown
15. Birthplace Germany

16. Informant Hospital Records

Address Sykesville Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof May 24 1940
(month) (day) (year)

Cemetery or crematory Balto. Md.

Location

18. Funeral director Wm J Lickner & Sons

Address Baltimore Md.

19. 5-22- 1940
(Date rec'd by registrar)

C. Harry Weer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1940 at 11.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 29 1940, to May 22 1940 and that I last saw her alive on May 22 1940

Immediate cause of death	DURATION
Diarrhoea and Enteritis	4-29-40
Due to	
Due to Involutional Melancholia	1917
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other

Address Sykesville Date signed 5-22-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 25 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH (77)

05335

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mo 25 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 11 mo 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hubbard

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hubbard

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Helen Eleanora Williamson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: (Mrs.) Williamson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 27, 1876.

8. AGE:

Years	Months	Days	If less than one day
63	8	27	..... hrs. ..... min.

9. Birthplace: (Hubbard) Maryland

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Solomon Jenkins

13. Birthplace: Maryland

MOTHER

14. Maiden name: Helen Beard

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25, 1940 (month) (day) (year)

Cemetery or crematory: Hancock Cem.

Location: Hancock Md.

18. Funeral director: Theodore A. Jenkins

Address: Hancock Md.

19. 5-23-1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1940, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4 1940, to May 23 1940 and that I last saw h.. alive on May 22 1940

Immediate cause of death	DURATION
Arteriosclerosis	1936
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maud M. Rees M. D.

M. D. or other

Address: Sykesville Md. Date signed 5-23-40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05336

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 1 yr., 1 month, 8 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Wye Mills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Richard Wilmer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (separated)

6 (b) Name of husband or wife: Edna Stewart Wilmer
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 7, 1894

8. AGE:

Years	Months	Days	If less than one day
46	3	25	hrs. min.

9. Birthplace: Wye Mills, Talbot Co, Md.
(Town, county, and atate)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: William Wilmer
13. Birthplace: Wye Mills, Talbot Co., Md.

MOTHER
14. Maiden name: Julia Brown,
15. Birthplace: Talbot County, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1940 (month) (day) (year)
Cemetery or crematory: Newtown Cemetary
Location: Talbott Co. Md.

18. Funeral director: Easton Sons
Address: Ellicott City Md.

19. 5/2/40 (Date rec'd by registrar) 19 Albert R. Swanhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1940 19 , at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1939 19 , to May 2, 1940 19 , and that I last saw him alive on May 2, 1940 19 .

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1938

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings: --

Of operations:

Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other Superintendent
Address Henryton, Maryland Date signed 5/2/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

05337

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 28 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Lawrence C. Wimert

3. (b) Social Security Number: 213-05-1622

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Julia B. Bowman

6(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): June 26, 1911

8. AGE: Years	Months	Days	If less than one day
28	10	27	hrs. min.

9. Birthplace: Westminster, Carroll, Md.
(Town, county, and state)

10. Usual occupation: Factory worker

11. Industry or business: Shoe manufacturing

FATHER
12. Name: Joseph D. Wimert
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes M. Utz
15. Birthplace: Maryland

16. Informant: Mrs. Julia B. Wimert
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/25/40 (month) (day) (year)

Cemetery or crematory: Leister's Cemetery

Location: rural near Westminster

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 5/24 1940 [signature] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 21 1939, to May 22 1940, and that I last saw him alive on May 22 1940.

Immediate cause of death: Myocardial degeneration & debilitation c. C.P.C.

Due to: Hypertension

Due to: Chronic Glomerulo Nephritis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION: ?

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Glenn Speicher M.D. or other
Address: Westminster Md. Date signed: May 23/40

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83-a)

05338

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 25 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ____ County ____
City or town ____ Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Mrs Margaret E. Winter

3. (b) Social Security Number: none

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edward H. Winter
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): August 8, 1864
8. AGE: Years 75 | Months 9 | Days 14 | If less than one day ____ hrs. ____ min.
9. Birthplace: Ba (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER: 12. Name: Benj F. Fleagle
13. Birthplace: Md
MOTHER: 14. Maiden name: Mary E. Marks
15. Birthplace: Md
16. Informant: Edward H. Winter
Address: Taneytown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24, 1940 (month) (day) (year)
Cemetery or ~~crematory~~: Lutheran
Location: Taneytown, Md
18. Funeral director: C D Duss & Son
Address: Taneytown, Md
19. May 24 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May - 22nd 1940, at 9:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on May 22nd ~~to~~ 1940, and that I last saw her alive on May 22nd 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: C. M. Benner MD M. D. or other
Address: Taneytown Md Date signed 5/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 3 1949
BUREAU V. S.

05339

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Taylorsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taylorsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. Mt. Airy, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: Mrs. Stella May Wright

3.(b) Social Security Number: None.

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband ~~or wife~~: Late William W. Wright.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17, 1878

8. AGE: Years: 61 Months: 11 Days: 20 If less than one day ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER
12. Name: Rezin A. Farver
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Catherine Haines
15. Birthplace: Maryland.

16. Informant: Mr. Earl Wright
Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9, 1940 (month) (day) (year)

Cemetery or crematory: Taylorsville Methodists.

Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. May 8, 1940 (Date rec'd by registrar) E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1940, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to May 7 1940 and that I last saw her alive on May 6 1940

Immediate cause of death: Coronary occlusion

Due to: Diabetes Mellitus

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

DURATION: 12 yrs.

Major findings of operations: —

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Jas. T. Thoash M. D. M. D. or other

Address: New Windsor Md. Date signed: 4/7/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) V

05340

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Cassell Home of the Aged
Stay in hospital or inst. (yrs., or mos., or days) 10 years
Stay in this community (yrs., or mos., or days) 5-9

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Main & Pennsylvania Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna K. Yingling

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Peter Yingling
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 16 - 1851

8. AGE:

Years	Months	Days	If less than one day
89	1	19	____ hrs. ____ min.

9. Birthplace Westminster, Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Jacob Myers
13. Birthplace Maryland

MOTHER
14. Maiden name Lydia Ensor
15. Birthplace Maryland

16. Informant Mrs Mikie Little Matron
Address Cassell Home of the Aged Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6 1940 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Maryland
18. Funeral director H. Bankard & Sons
Address Westminster, Maryland

19. 5/7 1940 H. L. Wood Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/10 1939, to 5/5 1940, and that I last saw h[illegible] alive on 5/4 1940.

Immediate cause of death	DURATION
(a) Cerebral Thrombosis	2 years
Due to (b) Carcinoma of Breast	8 years
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Chester Bare M. D. or other
Address Westminster Md. Date signed 5/6/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05341

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural Near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME David Milton Young

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of ~~husband or~~ wife Sarah Alice Koontz

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 1856

8. AGE:

Years	Months	Days	If less than one day
84	1	25	hrs. min.

9. Birthplace Westminster, Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Farmer Retired

11. Industry or business

FATHER 12. Name John D. Young

13. Birthplace Maryland

MOTHER 14. Maiden name Savilla Wood

15. Birthplace Maryland

16. Informant Mrs Samuel Baer

Address Westminster Maryland R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10. 1940 (month) (day) (year)

Cemetery or crematory Meadowbranch Cemetery

Location near Westminster, Maryland

18. Funeral director H Bankard & Son

Address Westminster, Maryland

19. 5/5 (Date rec'd by registrar) 1940 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1940, at 9 ~~P.M~~ A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/5 1940, to 5/7 1940, and that I last saw h~~er~~ alive on 5/7 1940.

Immediate cause of death

Lobar Pneumonia

DURATION: 3 days.

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore Baer
M. D. or other

Address Westminster Md. Date signed 5/9/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a)

05342

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 221 E. Main
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 83

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 221 E. Main
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Thomas Zahn

3. (b) Social Security Number None

4. Sex m
5. Color or race w
6. (a) Single, married, widowed, or divorced widowed
6 (b) Name of ~~husband or~~ wife Annie M. Grove
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 2 1857

8. AGE: Years 83 Months 3 Days 2 If less than one day hrs. min.

9. Birthplace Westminster (Town, county, and state)
10. Usual occupation Merchant retired
11. Industry or business General store
FATHER
12. Name Henry Zahn
13. Birthplace Austria
MOTHER
14. Maiden name Ida Anne Koons
15. Birthplace Maryland
16. Informant Grover Zahn
Address 221 E. Main St. Westminster
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-6-40 (month) (day) (year)
Cemetery or crematory Westminster Cem.
Location Westminster Maryland
18. Funeral director H Bankard Son
Address Westminster, Maryland
19. 5/4 1940 L. Avoodus (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1940, at 2 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about May 1st 1938, to May 4th 1940, and that I last saw him alive on May 3rd 1940.
Immediate cause of death Coronary disease
Due to arteriosclerosis
Due to Senility
Other conditions none
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION Some months

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Billingslea M. D. or other
Address Westminster, W. Date signed 5/4/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1940
BUREAU V. S.